***EXHIBIT 253***

***(Rev. 30, 12-15-07)***

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## *Organ Transplant Hospital Worksheet*

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***1. Date of Survey:*** *____/____/_____ (mm/dd/yyyy)*

***2. Type of Survey*** *(Check all that apply)*

- ☐ *Initial Certification*
- ☐ *Re-certification*
- ☐ *Follow-Up/ Re-Visit*
- ☐ *Validation*
- ☐ *Complaint*
- ☐ *Accreditation (Organization) _____*
- ☐ *Other (Specify)_____*

***3. Surveyor Number:*** *_____*

***4. National Provider Identification Number (NPI):*** *_____*

***5. CMS Certification Number (CCN):*** *_____*

***6. Name of Facility*** *_____*
*City_____ State_____*

***7. Host Hospital Accreditation Status:*** *_____*

*0 Not Accredited*
*1 JC Accredited*
*2 AOA Accredited*
*4 Both*

*Effective Date of Accreditation: _____*
*(mm/dd/yyyy)*
*Expiration Date of Accreditation: _____*
*(mm/dd/yyyy)*

***Which Programs Were Surveyed During This Review?***

| | *Surveyed During This Review (Check All that Apply)* | *Any tags cited during the survey? (Check if Yes)* |
|---|---|---|
| *Adult Kidney-Only* | | |
| *Adult Kidney/Pancreas* | | |
| *Adult Pancreas-Only* | | |
| *Adult Heart-Only* | | |
| *Adult Heart/Lung* | | |
| *Adult/Lung-Only* | | |
| *Adult Liver* | | |
| *Adult Intestine and/or Multi-visceral* | | |
| *Pediatric Kidney-Only* | | |
| *Pediatric Kidney/Pancreas* | | |
| *Pediatric Pancreas-Only* | | |
| *Pediatric Heart-Only* | | |
| *Pediatric Heart/Lung* | | |
| *Pediatric/Lung-Only* | | |
| *Pediatric Liver* | | |
| *Pediatric Intestine and/or Multi-visceral* | | |

***Send this Worksheet to the Contact Below:***

*Mail to:*
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*Survey and Certification Group*
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*Baltimore, MD 21244*

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